Nos. 95-1858, 96-110

In The

Supreme Court of the United States

October Term, 1996

DENNIS C. VACCO, Attorney General of the State of New York, *et al.*,

Petitioners,

v.

TIMOTHY E. QUILL, M.D., *et al.*,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

and

STATE OF WASHINGTON, CHRISTINE O. GREGIORE, Attorney General of Washington,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., *et al.*,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF *AMICI CURIAE* OF THE NATIONAL ASSOCIATION OF PROLIFE NURSES, NATIONAL ASSOCIATION OF DIRECTORS OF NURSING ADMINISTRATION IN LONG TERM CARE, PHILIPPINE NURSES ASSOCIATION OF AMERICA, SCHOLL INSTITUTE OF BIOETHICS, CALIFORNIA NURSES FOR ETHICAL STANDARDS IN SUPPORT OF PETITIONERS

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INTEREST OF *AMICI CURIAE*:

The decisions of the Courts of Appeal damage the liberty and property rights of nurses.

Letters of the parties consenting to file this brief *amici curiae* have been filed with the Court. Descriptions of each group filing this *amici* brief are set forth in the Appendix.

By striking state laws criminalizing assisted suicide, the decisions of the Courts of Appeal, if affirmed, would make assisted suicide legal. The *amici curiae* will be uniquely and directly affected by the Court's decision in this case. To demonstrate their unique interest, *amici* will present evidence that nurses would be 1) involved, and 2) detrimentally affected, if assisted suicide were made legal.

The decisions of the Courts of Appeal on review grant an entitlement not only to "physician-assisted suicide" but also (a fact unknown to many) to "nurse-assisted suicide." The practitioner most likely to be with the patient as he dies, is his nurse. A large difference exists between the professions of nursing and other professionals in illness care, regarding the care of terminal patients. The patients who are the subject of assisted suicide almost always require nursing care, not always medical care. At the very time when medicine may have little to offer the patient, the nurse can give comfort, concern, and care. The interest of nurses in what happens to their dying patients is unique, even among other professionals.

The nurses' interest differs from other professionals in another way: nurses are almost always employees. They will not have the luxury that other professions might have, abstractly and coolly to deliberate on whether to assist a patient in suicide. Nurses rarely can choose their patients; they are assigned to them. Because of their societal and employment status, nurses would be vulnerable to pressures to assist in suicide against their professional or ethical judgment. They are often in the unenviable position of being responsible for executing decisions in which they have no voice. The nursing coat of arms in some instances might well read: "Responsibility without Authority."

The effect of inculpating nurses in the self-killing of their patients will not be addressed by any other *amici* or Party. The effect is this: If assisted suicide is made legal, nurses will be asked to assist suicide. All nurses care for patients who die, and some of their patients might die by prescription. That nursing care would be nurse assistance in suicide, because the definition of "assist" cannot be narrowly limited only to providing medication. Those nurses and thus the whole profession would be inculpated in nurse-assisted suicide. Further, Nurse Practitioners (NPs) in several states now legally prescribe the medications that would be used to cause death in patients.

The Nurses' concern for their *patients* who would be harmed, will be addressed by other *amici*. Nurses add that the harm done to the profession of nurses, the largest group of practitioners who care for patients, would affect not only current patients but all who would need nursing care in the future.

All nurses would be involved intimately in the death of their patients who might self-kill. The decision of one of the Courts of Appeal contemplates this, together with an assumption that at some future time euthanasia may be delegated:

> "We recognize that in some instances, the patient may be unable to self-administer the drugs [for suicide] and that administration by the physician, **or a person acting under his direction or control** may be the only way the patient may be able to receive them." [Emphasis and material in brackets added]. *Compassion in Dying v. State of Washington*, 79 F.3d 790 at 831 (9th Cir.1996).

The inevitable inculpation of nurses in legal assisted suicide would erode the personal and professional ethics of nurses, expose them to criminal and civil sanctions, and destroy the confidence of the public in the profession. Thus the nurses' rights to liberty and property in the practice of their profession would be violated.

SUMMARY OF ARGUMENT

The decisions of the Courts of Appeal grant the entitlement to suicide with assistance and approval and thereby deny liberty and property rights of nurses in their profession, damaged irrevocably by nurse assistance in the deliberate deaths of patients. Nurses would be 1) inculpated, and 2) harmed, by legal assisted suicide:

1. Under legal assisted suicide, nurse practitioners and all other nurses would be inculpated in nurse-assisted suicide. One association of nurses already has advised its members that nurses would be involved in assisting suicide if it were legal.
2. Legal assisted suicide would harm irrevocably the ethical and legal basis of the nursing profession; current ethical standards of nurses would be eroded; and the public's perception of the profession would deteriorate, all causing damage to the liberty and property rights of nurses in practicing their profession.

ARGUMENT

To commit suicide with assistance and approval is not a right but an entitlement. Making assisted suicide legal does not merely allow the ability to do an act by one person, but confers the power to involve another person in the act.

Nurses leave to other *amici* the elaboration of the certain fact that the vast majority of people who seek suicide are psychologically impaired. Even terminal patients in pain do not seek death (and *amici* assert this pain can be relieved, under current standards of care). E.J. Emanuel, *et al, Euthanasia and physician-assisted suicide: attitudes and experiences of oncology patients, oncologists, and the public*, 347 Lancet 1805 (1996).

Terminally ill patients who seek to die are almost invariably depressed and ambivalent about dying, and those patients can be helped with medication. If encouraged, such ambivalent patients will choose to live. For the rare patient who is terminal, competent, non-depressed and seeking suicide with help (and even that patient is likely ambivalent about dying):

Before these Courts of Appeal decisions, prescriptions have been written with knowledge that their purpose was suicide. Though that information has been acknowledged, no prescribers have ever been convicted of assisting suicide. T.H. Stone & W.J. Winslade, *Physician-assisted suicide and euthanasia in the United States*, 16 J. Leg. Med. at 492 (1995).

The aim of making assisted suicide legal, then can be seen. It is not merely to allow a prescription for the few competent, terminal, non-depressed patients who would commit suicide with such drugs. Instead, it provides a prescription *with approval of its purpose*. This prescription would be visible evidence of approval of the act from the doctor or nurse practitioner. Legal assisted suicide confers the entitlement to suicide with approval, by inculpating the professions. The intent is to give to the act the imprimatur and approval of the law, and of the professional.

The tacit tolerance of assisted suicide already creates the perception that some special cases exist that warrant assisted suicide. This tolerance would become explicit if legal. The nurse would be forced to act either in compliance with her conscience (to safeguard her patient, profession, and opinion of herself), or to act in compliance with what would then be the law. She would have to be silent or even assist suicide.

1. Legal assisted suicide would inculpate all nurses in assisted suicide, denying nurses the liberty and property interests in their profession.

The relationship of nurses to their patients has been called a social contract with the public. That is, the public/patient knows in general what a nurse is, and what she is expected to do. People who are currently in the profession entered that work with the knowledge of, and expectation of, what their work would be. They have a property interest in their occupation; and they have a liberty interest in being able to practice the profession as it exists without arbitrary government interference. Both interests have been found to rise to the level of fundamental rights, deserving Constitutional protection.

> " . . . [T]he right to work for a living in the common occupations of the community is of the very essence of the personal freedom and opportunity that it was the purpose of the Amendment to secure."

Truax v. *Raich*, 239 U.S. at 41 (1915); and

> "[T]he right to hold specific private employment **and to follow a chosen profession** free from unreasonable governmental interference comes within the 'liberty' and 'property' concepts of the Fifth Amendment."

Greene v. *McElroy*, 360 U.S. at 492 (1959) [Emphasis and material in brackets added].

The liberty and property interests asserted here are not merely in a specific job, though specific employment also may be endangered for the nurse who will not participate. The nurse who will not participate in assisting suicide cannot merely go to another nursing job that is unaffected by legal assisted suicide. Any and all nurses would find their profession damaged by the inculpation of nurses in assisted suicide. All jobs, all nurses, would be tainted.

The practice of nursing does evolve and change; but the underlying values expressed in the ethics of nursing, and enforced in the minimum of the law, have not changed in thousands of years. The *amici* assert that it has not ever been the legitimate work of their profession to assist patients to kill themselves. Legal assisted suicide would make those acts part of the work of nurses.

Courts have always considered the effect of their decisions on all the people involved in a case. Under these decisions, the nurses are immediately and intimately and detrimentally involved. In particular, the impact of their decisions on the integrity of the professions has been of major concern to courts. *Superintendent of Belchertown* v. *Saikewicz*, 370 N.E.2d at 426 (Mass.1977), *Satz* v. *Perlmutter*, 362 So.2d at 163 (Fla.1980).

Other courts have expressed concern for nurses asked to assist in causing death in their patients (in the case quoted below, by denying nursing care).

> I find it difficult to understand how we can order nursing professionals with an abiding respect for their patients to cease to furnish the most basic of human needs to a patient in their care. [Such an order] may impinge on the privacy rights of those nursing professionals.

In re Jobes, 529 A.2d at 464 (N.J. 1987) (O'Hern, J., dissenting). [Material in brackets added].

Another court worried about the ethics of nurses asked to assist in deliberately dehydrating to death a comatose patient:

> . . . for almost all concerned the adoption of the proposed course will be a merciful relief, [but] this will not be so for the nursing staff, who will be called on to act in a way which must be contrary to all their instincts, training and conditions. They will encounter the ethical problems, not in a court or in a lecture room, but face to face.

Lord Mistill, House of Lords. *Airedale NHS Trust (Respondents)* v. *Bland* (Acting by his guardian *ad litem*) (Appellant) London: House of Lords, 1993 [Material in brackets added].

a. Legal assisted suicide would inculpate nurse practitioners as prescribers of drugs used in suicide.

If assisted suicide were legal, nurse practitioners in many states would be affected in exactly the same way as physicians. They would be seen as practitioners who could prescribe death instead of promoting life. In some states nurse practitioners potentially can prescribe all the drugs that patients seeking to suicide most likely would be prescribed to kill them. Drugs that might be prescribed are used at present for pain, sleep, anxiety, or depression, all of which categories some nurse practitioners legally can prescribe now. See, for example, Or. Rev. Stat. 678.385.

Patients who could legally obtain drugs for the purpose of suicide from physicians could get a prescription for the same or similar drug from a nurse practitioner. This is so, even if the NP technically could not prescribe for the *purpose* of suicide. If prescriptions from the physician for the purpose

of assisted suicide were legal, patients would be encouraged (and perhaps even more likely) to ask for the same drugs from their nurse practitioner. Patients who formerly might not have sought a prescription for suicide might be encouraged to do so if it were legal. The legality of the prescription would remove the stigma from suicide or at least spread it onto the prescriber.

Nurse practitioners in the future likely would be included as "prescribers" if assisting suicide were legal. The equal protection clause of the Fourteenth Amendment to the Constitution would prohibit the exclusion of Nurse Practitioners from prescribing drugs for self-killing. The limitation of such prescriptions to physicians would discriminate without rational basis, since nurse practitioners too could prescribe the drugs most likely to be used to kill the patient.

To assert that the prescription of killing drugs could be limited to physicians because they are better qualified to judge the mental status of the patient, has no factual basis. Comparison of the curricula of their respective educational programs would demonstrate that nurse practitioners (especially those working in mental health) are even more likely than doctors to have been educated in psychosocial components of care. Thus nurse practitioners are at least as able as physicians to assess patients for their competency in making a request to die. Nurse practitioners would be inculpated in legal nurse-assisted suicide as prescribers. Their exclusion will not meet the rational basis standard of Amendment Fourteen of the Constitution.

Nurse practitioners unwilling to assist the patient in suicide likely would be required to transfer medical records to the next practitioner chosen to assist suicide, just as physicians would be. This participation would be required, regardless of the religious or moral or professional objections of the nurse to inculpation in the self-killing. The nurse's objection that suicide was inappropriate for this patient, based on her assessment of the patient, would be no bar to enforcing such

transfer of records. An example of such requirement to transfer patient records in a law with "safeguards" as recommended by the decisions of the Courts of Appeal, is Oregon Ballot Measure 16, Section 4.01(4).

b. Nurses other than nurse practitioners would be affected by legal assisted suicide.

(1) The practice of every nurse would be changed by legal assisted suicide (which seeks to solve a nonexistent problem).

Legal assisted suicide would affect all nursing practice; most nurses care for terminal patients on a daily basis. Some of those patients (those who are depressed and ambivalent) might seek suicide with assistance. Participating in assisted suicide would become part of the practice of nursing. The consequences of legal assisted suicide noted below support that conclusion, and it is admitted by the position of the Oregon Nurses Association (ONA) discussed more fully below. Oregon Nurses Association, *Death with Dignity Act Position Statement* (1995).

If assisted suicide were legal, according to the ONA paper discussed below, even the nurse who is morally opposed to assisted suicide would be required to inform the patient of his right to referral to a physician (or nurse practitioner) who would prescribe a lethal dose. For some nurses, supplying this information would be assisting the patient's suicide. They would assist, as surely as did German nurses under National Socialism assist euthanasia. Those German nurses identified some children as retarded, knowing the result of the diagnosis would be death.

From the research done on attitudes and behavior of patients who are terminally ill, it is evident that the Courts of Appeal have written law to solve a problem that does not exist. Data cited above (Emanuel) show that patients who seek suicide are depressed and at least ambivalent about their wish to die. Practitioners are notoriously bad at diagnosing

and treating depression[1] (a reason to educate practitioners, not a reason to assist depressed patients to suicide). The data also show that competent terminal patients, even those (unnecessarily) in pain, are very unlikely to seek suicide.

According to research studies, a large majority of patients want heroic efforts made if they die. They may overestimate the success rate of heroic efforts, but patients who are very seriously ill, even those that might be classed as "terminal," want to live. R.S. Phillips *et al, Choices of seriously ill patients about cardiopulmonary resuscitation: correlates and outcomes*, 100 Am. J. Med. 128 (1996).

At present, the nurse's duty toward a depressed patient dying in pain is to alleviate the pain and treat the depression, both remediable conditions. If assisted suicide were made legal, the nurse's practice would be changed, perhaps to assist the patient to suicide in order to relieve depression and pain. Effective (non-lethal) treatment is available right now for depression and pain. *Amici* know it is not necessary to end the patient, to end his pain.

The Courts of Appeal have confused withdrawing treatment that patients do not want, with suicide, assisted suicide, and euthanasia. Researchers too have confused refusing treatment with suicide, resulting in studies that seem to indicate that intensive care nurses already assist suicide or euthanize patients. D.A. Asch, *The role of critical care nurses in euthanasia and assisted suicide*, 334 N. Eng. J. Med. 1374 (1996). In reality, only treatment that the patient rejects is removed. Often the treatment rejected would not have prolonged the patient's life in any event. The public (including jurists and researchers) overestimate also the success rate of medicine and nursing in prolonging life with heroic efforts.

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[1] Purported safeguards in legislation such as those in Oregon's Measure 16, ask the practitioner to refer the patient who may be depressed for counseling. But many practitioners cannot recognize the diagnosis in the first place, so they cannot refer. New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (May 1994) p. 127.

Though it may be blurry to the Courts of Appeal, the line is very clear and bright between withdrawing treatment which would not prolong life, and actively causing death. Nurses are adamant that care that is not useful, and is not wanted, be ended. The nurse is very often the patient's greatest advocate in such situations. She will take whatever measures are needed to see that the patient's wishes are honored. These measures may include conversations (even confrontations) with doctors, ethics committees and employers. But for the nurse, it is a thousand leagues distance from honoring her patient's wish to stop treatment – to being her patient's agent of death.

Under legal assisted suicide a nurse would encounter a family pressuring the terminal patient to die (subtly or not, and done for the patient's benefit or not). Currently, this behavior might rise to the level of neglect or abuse of an elderly or dependent patient, and the nurse's obligation is to report it. Under legal assisted suicide, the nurse's practice would be changed (perhaps to refer the patient and family to a practitioner who would prescribe a lethal dose).

Under legal assisted suicide, federal law might require nurses to inform the patient who is even possibly "terminal," of his right under state law to assisted suicide. The Patient Self-Determination Act 42 U.S.C. Sec.1395cc(a)(1) *et seq.* requires recipients of Medicare funds (hospitals, skilled nursing facilities, home health agencies, and hospice programs) to provide information to each patient concerning

> "an individual's rights under State law . . . to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives."

Even government employers may require practitioners to give information preferred by the employer's policy. *Rust* v. *Sullivan*, 500 U.S. 173 (1991). Private employers surely would be able to dictate information to be given. For employers of nurses such as managed care companies or their contractors (virtually all employers of nurses are included in the latter category), the patient's suicide or euthanasia might

be a very cost effective procedure. If the procedures were legal, nurses would be under pressure to assist suicide and euthanize. Nurses might be expected to suggest such "alternatives" to expensive care.

Nurses could be directed by their employers to tell patients that help in killing themselves is available, or be at risk of losing their jobs. Some nurses from strong religious and ethnic tradition, and other nurses who also place primary value on the life of the patient, would be especially at risk. If legal, such nurses who work on oncology and AIDS units, in long term care, hospice, and home health would find their job opportunities limited if they declined to participate in assisted suicide.

Nurses could be forced to choose between job and conscience in a time of shrinking job opportunities in nursing. Most nurses work as "at will" employees, vulnerable to covert and overt pressures to conform to employer goals. Nurses are career professionals, whose jobs usually provide the main source of income in their families. Many could not afford the luxury of maintaining their ethical standards at the cost of losing their livelihood.

(2) Hospice and home health nursing practice would be changed under legal assisted suicide.

Under legal assisted suicide, some hospice or home health nurse would visit her patient to find he had obtained a massive overdose of drugs. (If legal, it would be considered not an overdose but a "correct" dose to kill himself.) Before legal assisted suicide, the nurse would have assumed her duty was to help the patient live. After legal assisted suicide, the nurse's duty could conceivably be to counsel how best to take the drugs to assure death.

Under legal assisted suicide, some nurse who made a visit to check on her patient would find the patient had already ingested the prescribed overdose. (If legal, the dose would be called the "correct" dose – to kill the patient.) Currently, the nurse's duty is to call 911 and resuscitate.

Under legal assisted suicide, the nurse's duty might be to remain passively with the patient/family until the death. The ONA paper [cited below] suggests that if no other nurse were available, legal assisted suicide would create a duty to stay passively with the patient until death, regardless of the nurse's strong intent *not* to assist suicide.

The nurse whose patient would die by legal prescription would be inculpated in the death, because such a death is not so swift or sure or painless as might be assumed.[2] The patient may not die immediately or even within several hours or days. In addition to taking the prescription, proponents of suicide advise placing a plastic bag over the patient's head to assure asphyxiation if the patient awakens. This course of events is said to be not uncommon.

The ONA paper below suggests that even the nurse who did not wish to assist the patient in suicide, still would have to assume the patient's "end of life care" if assisted suicide were legal. If she were unable to transfer the suiciding patient to another nurse, she would have no choice but to participate.

Under legal assisted suicide, the nurse's duty might be changed horribly, perhaps extending to placing the plastic bag over the patient's head if the patient were unable to do so.

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[2] Prescribers for legal assisted suicide would not be competent to prescribe for a totally new purpose – to kill. To illustrate the problem: Excellent pain control measures are available, but many physicians and nurse practitioners are still unable to prescribe appropriate pain control for terminal patients. (This is not an excuse to kill the patient to relieve the pain, but a reason for more education of prescribers about the near 100% effective relief available.) Considering that current failing, it would be long before prescribers were good at killing. There is no scientific basis for this practice and doctors and nurse practitioners have had no experience in doing it. A new era of research would result if assisted suicide were legal. Such investigation of how to kill people yielded the Guillotine in the 18th Century, and the gas chamber in the 20th. It might well be asked what rough science slouches toward the 21st Century to be unearthed.

Eyewitnesses assert that it is sometimes necessary to hold the suiciding person's hands as he smothers, to keep him from forcefully removing the bag. The nurse's duty could extend to doing that.

If assisted suicide were legal, a hospice or home health nurse would find a suiciding patient alone and with no plastic bag. Currently the nurse's duty is to call 911 and resuscitate. Under legal assisted suicide the nurse's duty might be changed, to placing a plastic bag herself as noted above. Or her duty might be seen as passive, to leave the patient in a comatose state, visiting later to see if the patient died in the interim. It is highly impractical to say that the nurse would be obligated to stay with such a patient. Patients in a coma may take 11-14 days to die of dehydration (known from the experience of deliberately dehydrating to death, non-dying patients). Ruth Phillips, *The legacy of Nancy Cruzan,* 6(2) Living World 16 (1992).

A failed attempt could result in a very damaged patient, which would encourage or even mandate the nurse to ascertain that her patient does not fail. Nursing practice eventually might extend to directly killing the patient who failed in the suicide attempt. Legal assisted suicide does not prohibit active euthanasia; initially, it merely does not "authorize" it. For example see Oregon Ballot Measure 16, Section 3.14.

(3) Hospital and long term care nursing practice would be changed under legal assisted suicide.

Under legal assisted suicide, some patients prescribed a lethal dose would choose to take the drug in the hospital or long term care facility. One proposed "safeguard" legislation recognizes that possibility on its face.

> "If the patient [who wishes to suicide] is an inpatient at a health care facility, one of the witnesses [to the request for suicide] shall be an individual designated by the facility."

Oregon Ballot Measure 16, Section 6, "FORM OF THE REQUEST." [Material in brackets added.] The nurse designated by the facility would be faced with assisting suicide at least to the extent of witnessing the patient's request, regardless of her moral, ethical and professional objections.

If the nurse on duty in a hospital or other inpatient facility knows of the patient's plan to suicide beforehand, her duty might change from trying to save the patient's life – to assisting with his death. Currently the nurse continues nursing care for the patient who is dying; turning the patient, suctioning secretions, administering medications, etc., to help the patient *live* comfortably. Under legal assisted suicide, the nurse's practice would change. The duty logically might be to do whatever would cause the patient to die sooner.

Under legal assisted suicide, the "worse" the nurse by present standards (that is, the faster and better at killing), the better for the patient. The "better" the nurse by present standards (that is, the more life-saving, caring), the worse for her patient under legal assisted suicide. The *amici* assert: This situation stands nursing practice on its head.

These vignettes look macabre, but they are not worst-case scenarios; they are the likely situations that nurses would encounter if the Courts of Appeal are affirmed. Immediately, intimately and inextricably, nurses would be inculpated in assisted suicide.

Nursing "care" would be redefined to include the killing of the patient, and assistance as the patient self-kills. Nursing theory would be developed to teach students how to "care" (or, in every accurate usage of the word, how *not* to "care") for patients committing suicide. Continuing education would be needed for current nurses, on how to assist patients being killed by self-administration of drugs. If assisted killing were extended to people unable to self-administer the drugs (as would be likely), nurses would be taught to kill patients directly.

Nursing education and curricula would be changed to incorporate the "new" ethic and law and nursing practice: Some patients would be given good care. Some patients' "good care" would include giving them prescriptions to kill

themselves. And some patients' "care" would include killing them.

c. Anticipation of legal assisted suicide in one state has caused its nurses to accept involvement.

The threat of legal assisted suicide in one state already has prompted a paper in which the nurses association accepts that nurses will be involved in their patients' suicide. In anticipation that legal assisted suicide would be implemented, and to prepare their members for that reality, the Oregon Nurses Association (ONA) adopted a position statement to guide nurses in the care of terminal patients under legal assisted suicide. Oregon Nurses Association, *Death with Dignity Act Position Statement* (1995).

The ONA document asserts that the nurse's role under legal assisted suicide would be "to share information about health choices **that are legal**." [Emphasis added] Oregon Nurses Association, p. 3. This statement is evidence that nurses will be involved if assisted suicide is legal. Nurses would be expected to teach patients about the option of killing themselves. Mere legality (not any higher ethical standard) would be the defining parameter of the nurse's behavior.

Theoretically, under the Oregon "safeguard" legislation which proposed to make assisted suicide legal, the nurse could refuse to care for a patient who chooses to kill himself. But the ONA paper admits that if she couldn't transfer the patient, "the nurse has the responsibility to provide for ongoing end of life care." Oregon Nurses Association, p. 3. Transfer might be impossible if the nurse discovered the suicide attempt after the patient had taken the poison. Requesting and securing a replacement nurse from her agency (if even granted) could take longer than the patient had to live. Nurses could not opt out of legal assisted suicide, no matter what the language of any "safeguard" legislation adopted by a state legislature.

Nurses are competent to make professional judgments about the mental and physical status of their patients that would affect the appropriateness of a request for suicide.

Further, they are competent to make moral judgments for themselves, about the appropriateness of suicide for any person at any time. Regardless, under legal assisted suicide, the ONA paper asserts that the nurse would be involved and would be muzzled:

> "You may not subject your patients or their families to unwarranted, **judgmental** comments or actions because of the patient's choice [to kill himself]."

Oregon Nurses Association, p. 4. [Emphasis and material in brackets added].

The nurse would be involved, her professional judgment would be thwarted and her freedom of speech compromised under legal assisted suicide.

The ONA position paper is evidence that legal assisted suicide would inculpate nurses fully in assisted suicide, and to the detriment of the practice of the profession.

2. Legal assisted suicide would harm the ethics and law of nursing; the threat already has done harm.

a. Legal assisted suicide would erode the ethics and law of nursing.

The inculpation of nurses in assisting patients to kill themselves causes the degeneration of the ethics and law of nursing, which are based on six values (elaborated below): Doing No Harm, Doing Good, Being Free, Being Fair, Being True, and Life. The position of the American Nurses Association (ANA) states the ethical foundation of nursing practice:

> "The goals of nursing are the promotion, maintenance, and restoration of health, the prevention of illness, and the alleviation of suffering. The social contract between nursing and society to meet these goals is based upon a code of ethics that is grounded in the basic ethical principles of respect for persons, the noninfliction of harm, and fidelity to recipients of nursing care. These principles command that nurses protect or preserve life, avoid doing harm, and create a relationship of trust and loyalty with recipients of nursing actions."

American Nurses Association, *Position Statement on Capital Punishment* (1988).

The ethical standards of conduct (a higher ideal) are used by lawmakers in making lower, legal minimum mandates. Nursing law is the minimum enforcement of nursing ethic. It is the arbitrarily drawn line that separates desired behavior (ethics) from mandated behavior (law). The law exists to guide people who have no higher ethic. People who will not do right voluntarily, can be made to do at least a minimum of "not wrong" with law.

Those people, and others who have no moral compass, will take the law as the highest, not the lowest, standard of behavior. For them, the law becomes the ethic. "It's legal, therefore it must be ethical" is the reasoning. If the nurse who assists suicide were acting legally, some then would assume that she was acting ethically, too.

As noted below regarding nurse participation in executions, the nursing profession nationally has not succumbed to that lowest level of behavior. The national nursing associations, such as the American Nurses Association (ANA) and the National Association of Prolife Nurses, set and promote professional standards of ethics. Those standards cannot be varied according to popularity poll, nor may they descend to whatever acts the popular will has made temporarily legal. As an analogy to assisted suicide: Nursing leaders have suggested that nurses who participate in executions – even if the act is legal – are so far below the ethical standard required of nurses, that their licenses should be revoked.

Assisting a patient to kill herself, merely because it is legal, should not change the standards of nursing practice and ethics; but it would. The legal standard of nursing would be so low that merely to meet it would violate nursing ethics. The standard of nursing ethics and nursing practice would inevitably be ratcheted down to a lower level commensurate with the law.

Some nurses would do whatever is legal. That is why it is not sufficient to say that nurses can protect the ethics of the nursing profession simply by voluntarily refusing to participate in legal assisted suicide. Unlike the isolated participation

in legal executions by a few nurses, *all* nurses are intimately involved in the lives and deaths of dying patients. Under legal assisted suicide, nurses would be inextricably inculpated in their patients' suicides. The erosion of the law would corrupt the ethic correspondingly. Law would lead instead of follow the ethic, and would irreparably harm the profession of nursing.

The ethics and the resulting law of nurses are based on the following six values held by nurses (and all the illness care professions): Doing No Harm, Doing Good, Being Free, Being Fair, Being True, and Life. J.K. Hall, *Nursing Ethics and Law* (1996). Discussion of each value follows with its resulting ethic and law and the changes that legal assisted suicide would cause. As the law deteriorates, so do the ethics.

DOING NO HARM

Legal assisted suicide would damage the nursing ethic and law based on the value, *Doing No Harm* (Non-maleficence). That value is enforced by criminal law, civil intentional tort law and licensure law. Currently, nurses can be prosecuted under their licensure law which in most states allows license revocation for conduct which can be characterized as gross incompetence or gross negligence. See, for example, Or. Rev. Stat. 678.111(b). Presently, assisting deliberately caused death in a patient could be characterized at least as gross incompetence or as gross negligence, if not intentional harm. If assisting suicide were legal, the nursing licensure law would have been dramatically changed.

Assisting deliberately caused death now would surely be "conduct derogatory to the standards of nursing," also grounds for licensure discipline in most states. See for example, Or. Rev. Stat. 678.111(f). Again, legalizing assisted suicide would change the licensure law. As noted above, the standards of nursing have been national parameters, not community or state standards subject to the vagaries of what lawmakers set. But the law will lead those who have no ethical guide, and if assisted suicide is legal, nurses who

assist will seem to meet the minimum standard of nursing practice.

Presently, the nurse whose terminal patient is being pressured to commit suicide may be obligated to report that as neglect or abuse of an elderly or dependent patient. See for example Or. Rev. Stat. 410.610 *et seq.* (elderly) and Or. Rev. Stat. 441.630 *et seq.* (nursing home). If assisted suicide were legal, such encouragement might be considered the right thing for family or nurse to do.

Under legal assisted suicide the enforcement of these laws preventing harm to the patient would change. "Safeguard" legislation (such as that passed in Oregon) would have to provide that nurses would not be subject to criminal or civil liability or professional disciplinary action for assisting suicide. Such law would erode the authority of the board that regulates nursing, and any other agencies that enforce the law that prohibits and punishes harm to patients. Allowing nurses to assist in suicide would erode the minimum ethic enforced by the law, and correspondingly lower the standards expected of nurses generally.

DOING GOOD

The nursing ethic based on the value *Doing Good* (Beneficence) is enforced in malpractice law. Currently, when nurses fail to do good (as a reasonable prudent nurse would do), even unintentionally, they are subject to liability. Currently, nurses are not relieved of their own liability for their actions by physician orders and actions or patient wishes; nurses are morally and legally liable for their own malpractice. See generally, *Nurse Liability for Own Malpractice*, 51 ALR 2d 970.

Legal assisted suicide would change the nursing malpractice law. The standard of care of the "reasonable prudent nurse" would be changed from obligation to *save* the patient's life, to obligation to help *end* it in some situations. As noted above, under legal assisted suicide, the nurse would be obligated to inform the patient about the availability of assisted

suicide. Regardless of her personal moral convictions or professional assessment that the patient can be helped short of suicide, the patient or survivors might bring an action for subsequent pain and suffering based on a negligence theory if she did not so inform.

On the other hand, nurses who did refer or assist the patient who sought assisted suicide, might also be liable. The theory of liability could be failure to assess adequately for depression or decisional capacity, or failure to challenge the prescriber's assessment and prescription if they were faulty.

The family member or the estate who learns about the nurse's involvement in the attempt might have a cause of action for malpractice or wrongful death. The family might notify the licensure board of the nurse's action, alleging failure of nursing care. (Though as noted above, the licensure board might be powerless to enforce standards after legal assisted suicide.)

BEING FREE

Legal assisted suicide would damage the nursing ethic based on the value *Being Free* (Autonomy), enforced by consent law. The nurses leave to other *amici* to elaborate on the obvious fact: The patient's autonomy must *not* be honored and he must be protected from himself, if he is not competent to make decisions. That is the situation if the patient is depressed or suffering from mental illness, which almost all suicidal patients are.

The right of the patient to refuse treatment is stronger than the grant of an entitlement (as in legal assisted suicide), but even that power of refusal is not absolute. The right is conditioned on the impact on other people; for example, the power to refuse a transfusion may be conditioned on the patient's responsibility for another person.

Nurses have some rights to their own autonomy. The patient's demand for treatment which transgresses the professional's ethics cannot be honored. For example, the patient's demand to remove a healthy body part (because the person wanted to qualify as disabled) must be declined by the ethical

physician. Even an *un*ethical doctor would face legal sanctions for performing such a procedure. Government cannot arbitrarily inculpate the professions in such entitlement, to the detriment of their fundamental liberty and property rights to practice their profession with autonomy.

A rough analogy to the damage to nurses' autonomy under legal assisted suicide: Imagine a law granting the entitlement to assisted suicide with the help of a police officer to accomplish the killing. The damage is obvious to the ethic of police officers, whose professional responsibility is to protect innocent life. As noted above, the reason to have a professional assist is to put her imprimatur on the act.

Another analogy of damage, to another profession that might serve as provider of assisted suicide (and whose ethics much of the public already consider to be below reproach) is the legal profession. A recent article describes the perception that lawyers will do whatever their clients order, without reservations based on personal integrity or professional ethics. The authors suggest, perhaps not tongue-in-cheek, that the legal profession might be the ideal suicide assistants. R.M. Sade & M.F. Marshall, *Legistrothanatry: A new specialty for assisting in death*, 39(4) Perspectives in Biology and Medicine 547 (1996).

The American Nurses Association addresses the fine line separating the patient's autonomy from the moral mandates and integrity of his nurse:

> "Though there is a profound commitment both by the profession and the individual nurse to the patient's right to self-determination, limits to this commitment do exist. In order to preserve the moral mandates of the profession and the integrity of the individual nurse, nurses are not obligated to comply with all patient and family requests. The nurse should acknowledge to the patient and family the inability to follow a specific request and the rationale for it."

American Nurses Association, *Position Statement on Assisted Suicide* (1994) p.4.

BEING FAIR

Legal assisted suicide would damage the nursing ethic based on the value *Being Fair* (Justice), enforced by laws requiring equal treatment under the law. Other *amici* will discuss the laws that enforce fairness toward patients in this country. They include the due process and equal protection clauses of the Fifth and Fourteenth Amendments to the Constitution, the Americans with Disabilities Act, and the prohibition against discrimination toward some groups who are more likely to experience pressure to die if assisted suicide were legal.

Amici assert, as detailed above, that the fundamental fairness due nurses under the Fifth Amendment would be violated under legal assisted suicide.

BEING TRUE

Legal assisted suicide would damage the nursing ethic based on the value *Being True* (Loyalty), enforced at a minimum in law by contract law, confidentiality, informed consent, and by law requiring nurses to be advocates for patients. Nursing law mandates that nurses must be advocates for the patient, even if their action is counter to the physician or employer's order.

The changes in nursing practice that legal assisted suicide would force (elaborated above in descriptions of nurse involvement under 1.b.) are severe dislocations of the nurse's ethical and legal duties of loyalty to the patient. Under legal assisted suicide, the nurse's duty to advocate for the patient might become the duty to advocate death for the patient.

LIFE

Legal assisted suicide would damage the nursing ethic based on the value *Life*, enforced by all law that outlaws killing. Though mentioned last, this is the first value of nurses, or the one that underlies all others. The *sine qua non* of nursing ethic is promoting the life of the patient in all aspects, including the comfort of the patient and her value as

an individual. This is so, even and especially as the patient is dying. Promoting and protecting the dying patient's life cannot be subverted to mean assisting her deliberately to kill herself.

At present, the life of the individual is protected by the law, overridden only in extreme circumstances. For example, killing is justified only under narrow conditions such as self-defense, executions, or war.

Under the decisions of the Courts of Appeal, some lives would *not* be protected by law. People who are diagnosed "terminal" would not be protected from assisted suicide. But people who were not dying, *would* be protected from assisted suicide. The assumption underlying that situation: People who are not dying are more valuable than the dying.

Nurses do not discriminate in their care, between patients whose lives are less valued and more valued. This stratification of lives into levels of protection – some more valued, some less valued – is not a new concept. The framers wrote the U.S. Constitution, and courts subsequently have interpreted that Constitution, precisely to *prohibit* laws that classify lives in that way. Yet one of the decisions on review, responding to the state's contention that its principal interest is in preserving the life of all its citizens, answers:

> "[W]hat interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes."

Quill v. *Vacco*, 80 F.3d at 729 (2d Cir.1996).

b. The national standard of ethics for nurses is that nurses do not assist patients to kill themselves, but threat of legal assisted suicide in one state has caused erosion of that standard.

To state the obvious: The consensus of nursing ethics is that nurses do not assist patients to kill themselves.

The maintenance of the ethical integrity of the professions involved is one of the primary interests Courts weigh in

such cases as these. *Superintendent of Belchertown* v. *Saikewicz*, 370 N.E.2d at 426 (Mass.1977), *Satz* v. *Perlmutter*, 362 So.2d at 163 (Fla.1980). The court in *Superintendent of Belchertown* took care to find that its decision was in accord with the "prevailing ethical practice" of the profession. The prevailing ethical practice of the nursing profession is *not* to assist patients to deliberate death, evidenced by the following statements of ethics of American nurses.

The American Nurses Association maintains that nurses may not ethically assist suicide (as they would be asked to do under legal assisted suicide):

> "Nurses, individually and collectively, have an obligation to provide comprehensive and compassionate end-of-life care which includes the promotion of comfort and the relief of pain, and at times, foregoing life-sustaining treatments. The American Nurses Association (ANA) believes that the nurse should not participate in assisted suicide. Such an act is in violation of the Code for Nurses With Interpretive Statements (Code for Nurses) and the ethical traditions of the profession."

American Nurses Association, *Position Statement on Assisted Suicide* (1994) p.1.

The national Oncology Nurses Society endorsed the ANA position in 1995. Oncological Nurses Society, *Endorsement of ANA Position Statement on Active Euthanasia and Assisted Suicide* (1995). The American Association of Critical Care Nurses has endorsed as well.

The National Association of Prolife Nurses and its affiliates oppose assisted suicide in the strongest terms, believing it tantamount to euthanasia:

> "The public must be assured that we will not participate in euthanasia or refer people to individuals and organizations supporting euthanasia, and that we consider euthanasia to be medical murder."

Nancy Guilfoy Valko, *National Nurses Group Supports Resistance to Euthanasia*. National Association of Prolife Nurses (1994).

Though addressed to the prohibition against nurses' participation in executions, the following encompasses the ethical standard of the ANA for causing death in patients:

> "Regardless of the personal opinion of the nurse on the moral appropriateness of capital punishment, either generally or specifically, it is a breach of the ethical tradition of nursing, and its Code for Nurses, to participate in taking human life, even through a legally authorized civil or military execution."

American Nurses Association, *Position Statement on Capital Punishment* (1988).

The *amici* would add that it is a breach of the ethical tradition of nursing to participate in taking human life, even through a legally authorized nurse assisted suicide as would be possible under legal assisted suicide.

Further nurse ethical standards:

> "The nurse acts to safeguard the client and the public when health care and safety are affected by incompetent, unethical, or illegal practice of any person."

American Nurses Association, *Code for Nurses* (1986).

The nurse mandate to safeguard the patient from "any person" must include physicians or other nurses who prescribe or administer drugs to cause death.

And yet another ethical standard that nurses must not aid death:

> "Nurses . . . must take all reasonable means to protect and preserve human life when there is hope of recovery or reasonable hope of benefit from life-prolonging treatment. The nurse does not deliberately act to terminate the life of any person."

American Nurses Association, *Code for Nurses with Interpretive Statements* (1986).

As noted above under 1.c., the anticipation of legal assisted suicide in Oregon has resulted in a position statement by the Oregon Nurses Association. That paper admits that nurses would have to participate or assist in their patient's suicide in several ways –

> informing patients of "choices that are legal" (as noted above, to some nurses this would be tantamount to encouraging suicide),
> "providing for ongoing end of life care" for suiciding patients if the patient couldn't be transferred (very likely if the nurse learned of the suicide attempt after the prescription were ingested), and the nurse could make no "judgmental comments or actions because of the patient's choice [to kill himself]," muzzling the nurse's ethical or professional assessment of the patient's choice.

Oregon Nurses Association, *Death with Dignity Act Position Statement* (1995) p. 4 [Material in brackets added]. As can be seen, the threat of legal assisted suicide in Oregon resulted in a position paper from the ONA which copes with that potential reality, by lowering ethical standards to the minimum ethic: Whatever might be made legal is ethical.

In addition to the assault on their professional ethics, many nurses would have personal ethical problems in assisting suicide – though as outlined above and noted under the ONA paper, they would have little choice under legal assisted suicide. Considering the shrinking job market faced currently, nurses would be under great pressure to comply with the employer who requires them to participate with patient suicide.

Some nurses already have been disciplined with job suspension for six weeks for reporting (or for not reporting fast enough – the employer's version) an active euthanasia performed on a child by the physician. *Death at U.C. Med Center,* San Francisco Chronicle, 3 April 1995, A20; *UCSF suspends nurses who delayed reporting incident*, NURSEweek, First April 1995, 3, 20. Under legal assisted suicide, the pressure would increase on the nurse to look away from patient abuse or to lose her job.

Under legal assisted suicide nurses who are religious would face a compromise to the very fundamentals of their morality – encompassed in any version of "Thou shalt not kill." Exodus Chapter 20, Verse 13. Nurses who are not formally religious are no less spiritual, and no less harmed by such an egregious violation of their personal ethic.

Other *amici* will inform the Court of the fact that all medical associations in the world (save Holland's) oppose assisted suicide. They will describe the experience in Holland in which even the tacit legal approval of euthanasia and assisted suicide – far short of the outright legal assisted suicide as proposed by the Courts of Appeal – has become a large problem, for the society, the professions, and most of all the patients of that country.

3. Legal assisted suicide would inculpate nurses in assisting suicide, damaging the profession in the eyes of the public.

a. Under legal assisted suicide, some nurses *would* assist in patient killing.

No illusions may be indulged; under legal assisted suicide, some nurses would be ready, willing and able to assist suicide. Some would kill patients directly if assisted suicide were extended to the disabled who are unable to self-administer the drugs.

The experience of nurses in the 1930's under Germany's National Socialism is instructive. Though some would wish it not so, 1990's American nurses too would be vulnerable to pressures if killing were made legal. Under National Socialism, some nurses and their associations collaborated when Hitler's euthanasia program was legal.

Some German nurses deliberately administered barbiturates to mentally retarded children that they had selected; the children slept for long periods, developed pneumonia as a result, and died a "natural" death. The death certificates read "Pneumonia," but in the consensus of world opinion, ten and now fifty years after, those nurses caused the deaths of those children. *Testimony of Dr. Valentin Falthauser, 22-23 April 1948; and Nurse Mina Worle, 7 May 1948 (Kaufbeuren asylum)*, Heyde Trial, pp. 143-47, in Robert Jay Lifton, *The Nazi Doctors* (1986) p.55.

The nurse associations of Germany collaborated in changing the ethics of the profession to conform to the legal mandates of the National Socialist government. Hilde Steppe,

Nursing in Nazi Germany 14(6) West. J. Nurs. Res. 744 (1992). Some nurses were not, would not be, immune to pressures to eliminate the problem patient instead of eliminating the patient's problem.

b. If legal, future killing would be delegated to nurses.

In addition to the immediate consequences of legal assisted suicide to the profession, the *amici* have reason to worry about their even worse role in the future. Under legal assisted suicide *amici* believe assisted suicide would be extended to actual administration of "suicide" to the disabled and incompetent. Allowing only competent able patients to kill themselves with prescribed drugs inevitably would be held to discriminate against the disabled who can't self-administer the drugs, and against the incompetent who can't request the killing drugs. At that point, prescribing suicide or even direct euthanasia would fall to the nurses as does other dirty work.

In support of that prediction: Technical procedures always are delegated eventually. When blood pressure measurements were first available, only doctors were allowed to perform them. At present, the *amici* are confident that few members of the Court have ever had their blood pressure measured personally by a doctor. When first developed, the technology of intravenous medication was limited to doctors (as late as the 1970s it was not taught in nursing curricula), as was administration of chemotherapy, and virtually all intensive care technology, including interpretation of electrocardiograms.

Today, in various states, nurses can perform all those procedures; in addition, nurse practitioners may set broken bones, suture wounds, and prescribe almost all drugs that physicians can. Under legal assisted suicide, it would be a short matter of time before this last worst "technique" of assisting suicide would be delegated to the nurse.

c. Allowing nurses legally to assist suicide would result in deterioration of the public's trust in their profession.

The public's perception of nurses would change under legal assisted suicide as nurses came to be seen as people who assist with killing. The public would lose confidence in nurses, and would be suspicious of the nurse's intent when she nursed patients labeled "terminal." The social contract that nurses have with the public would be breached. The ANA believes that trust to be essential:

> "Nursing has a social contract with society that is based on trust and therefore patients must be able to trust that nurses will not actively take human life. The profession's covenant is to respect and protect human life (Nursing: A Social Policy Statement). Nurse participation in assisted suicide is incongruent with the accepted norms and fundamental attributes of the profession."

Position Statement on Assisted Suicide, p.4.

Assisting in deliberate killing of patients, either by prescribing self-administered medications (nurse practitioners), or by tacitly approving of the patient's decision to die by participating in their care as they suicide – would violate the nurses' social contract with their patients and result in the public's loss of trust in the profession.

If nurses could assist suicide legally, the public's perception of nurses would change. Nurses who could assist in suicide would be seen not as trusted advocates but as people who carry out orders regardless of their effect. They would not be seen as professionals with autonomy and independent judgment, but as lackeys who do the patient's or doctor's bidding no matter how heinous the morality of the order.

Patients would not trust nurses who were handmaidens to physicians prescribing death, and who were unquestioning, "nonjudgmental" servants to any patient with a prescription. At present, the wish to die to the nurse is a cry to help the patient to find reason to live. Under legal assisted suicide, it

would be a mandate to nurse the patient to deliberate death. The public's opinion of nurses could not help but decay.

The nurse's liberty to practice nursing as she knew it and chose it and learned it would be curtailed. Her property interest in working at her profession would deteriorate. Hers then would be a profession with an ethic of promoting or assisting patients to deliberate death, instead of to life.

CONCLUSION

Legal assisted suicide creates an entitlement to assistance with, and approval of, suicide. It inevitably will inculpate nurses in the killing of their patients. It would destroy the public's confidence in the profession of nursing, damaging the nurses' liberty and property rights to practice that profession. It purports to help patients who either do not wish to die (terminal patients, even those in pain) or who are treatable and would be treated if society valued their lives (terminal patients who are depressed and ambivalent). That unwanted, unneeded entitlement is granted to the awful detriment to the fundamental rights of nurses who wish to practice their profession uncorrupted.

Based upon the above, the decisions of the Courts of Appeal should be reversed and the cases remanded for disposition in accordance.

Respectfully submitted,

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November 8, 1996 *Attorney for Amici Curiae*

APPENDIX

Statements of Interest

This brief *amici curiae* is submitted to the Court by people who will be uniquely and directly affected by the Court's decision in this case. *Amici Curiae* are:

The National Association of Prolife Nurses, nurses who promote and protect the lives of patients at all stages of life, was formed in 1973 with state affiliates and members in all states. Their activities on behalf of patients, and on behalf of nurses who protect patient lives, include legal representation, education, and organization. The members have supported an *amicus* brief to the Ninth Circuit in the case challenging the legalization of assisted suicide in Oregon still pending there.

The National Association of Directors of Nursing Administration in Long Term Care, the managers of facilities where some patients are cared for who would be subject to assisted suicide if legal, was formed in 1986, and has 30 state affiliates with 4000 members from all states. Their code of ethics mandates they support and promote quality of care for those individuals receiving long term care, and concern for those delivering long term care.

The Philippine Nurses Association of America, nurses of Philippine ethnicity who live and work in the U.S., was formed in 1979, and has 25 state affiliates with over 2000 individual members. Their endorsement of the Code of Ethics of the International Council of Nurses mandates they protect, promote and restore health when possible, prevent illness when possible, and alleviate suffering; thus

they believe the legalization of nurse assisted suicide and euthanasia will change the very essence of nursing practice.

The Scholl Institute of Bioethics, a group of professionals in medicine, law, psychology and religon, was established in 1986 because of concern for the increasing difficulty of bioethical decisions that both individuals and the medical profession are facing in relationship to today's modern advances in medicine and the growing euthanasia movement.

California Nurses for Ethical Standards, a non-profit educational and professional organization of nurses who promote in all respects ethical standards of health care, was established ten years ago in the state of California. The members believe that euthanasia and assisted suicide violate all nursing ethics codes.
